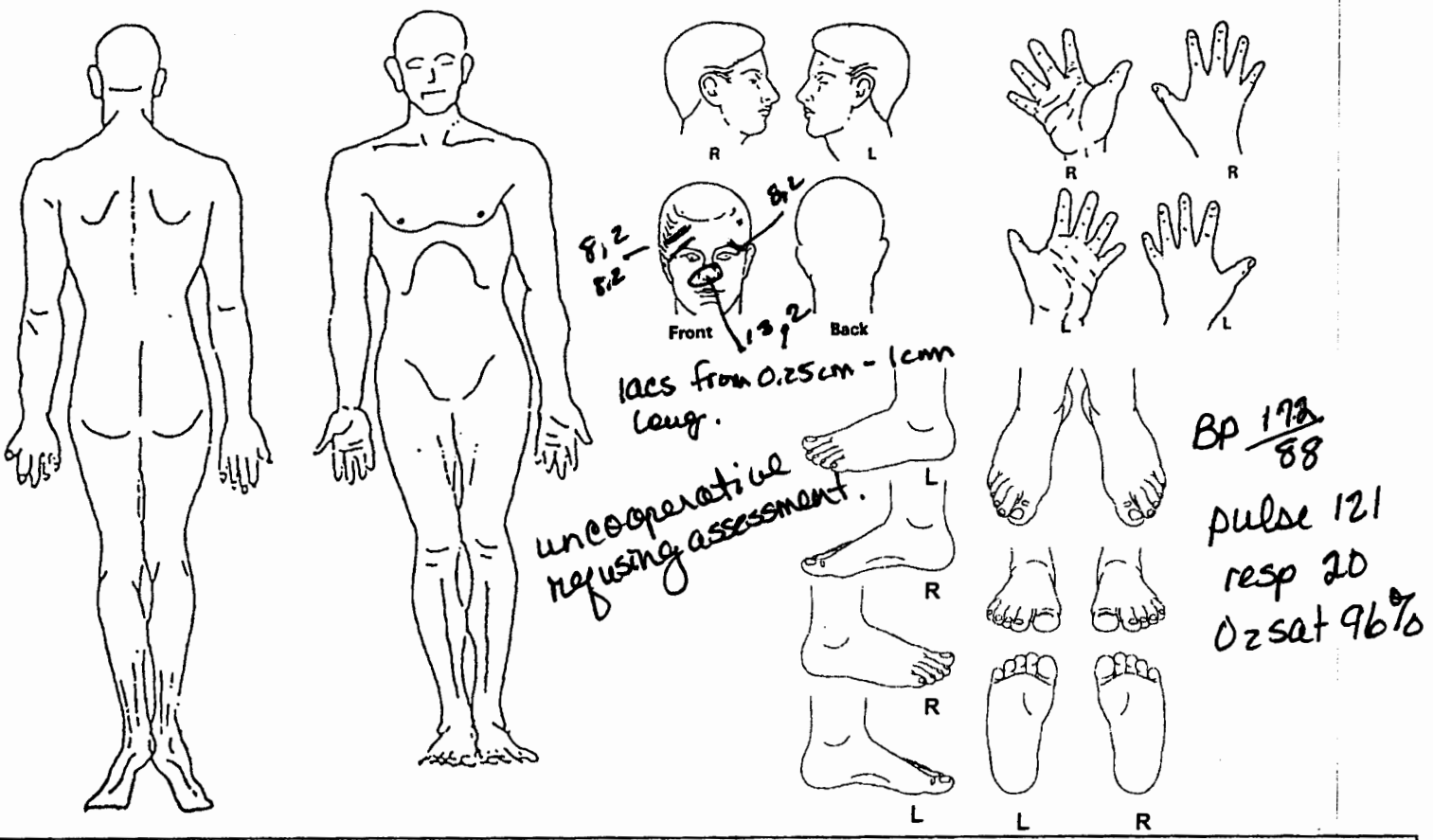
SPECIAL REPORT

Exhibit 2:

Medical

13-34A2

Facility Emergency Anatomical Form



lacs from 0.25cm - 1cm long.

uncooperative refusing assessment.

BP 178/88
pulse 121
resp 20
O2sat 96%

☒ Inmate/Resident ☐ Employee

Facility Name: OCF Date: 12/29/16 Time: ~~1340~~ 1332

Name: (Last, First) Davis, Jerard D. Agency # / Employee#: 688165

Age: 26 Race: Black Sex: ☒ male ☐ female Time Notified: 1315 Time Seen: 1332

Place of Occurrence: FB 2/12 Date/Time of Occurrence: 12/29/16 @

Reason for Report: ☐ injury ☐ on the job injury ☒ use of force ☐ pre-seg admission ☐ other:

Mode of Arrival? ☐ wheelchair ☒ ambulatory ☒ on-site ☐ escorted by SORT

Injuries Found? ☒ Yes ☐ No - If yes, use the appropriate code number on the figures above

Abrasions/Scratch	1	Fresh Tattoo	7	Reddened Area	13	Other, list below	
Active Bleeding	2	Cut/Laceration/Slash	8	Skin Flap	14		17
Bruise/Discoloration	3	Chemical Spray Area	9	Swollen Area	15		18
Burn	4	Pain	10	Open Fracture	16		19
Deformity	5	Protrusion	11				
Dried Blood	6	Puncture	12				

RN Notified: RShirley RN
Time: 1332
LIP Notified:
Time:
Form Completed By/Title:
Print/Sign RShirley RN

Chemical Spray Exposure? ☒ Yes ☐ No **Decontaminated?** ☒ Yes ☐ No **Self-decontamination instructions given?** ☒ Yes ☐ No
Refused Decontamination? ☐ Yes ☒ No **Placed on every 15 minute respiratory checks?** ☐ Yes ☒ No
Brief Statement in subject's words of the circumstances of the occurrence:

Comments: belligerent and disruptive. refused assessment.

Disposition: Shower. Time: 1350

10/10/12

OKLAHOMA DEPARTMENT OF CORRECTIONS
REQUEST FOR HEALTH SERVICES

TO BE COMPLETED BY OFFENDER Facility: DCF Date: 1/2.17

Offender Name Jerard Davis DOC # 168165 Unit FC 101

I request the following service(s): (Check appropriate box(s))

☑ Medical ☐ Mental Health ☐ Dental ☐ Optometry (eye) ☐ Medication Renewal (expired medications only)

Reason for service: My feet is swelling and my toes are numb.

I understand that in accordance with operations memorandum OP-140117 entitled "Access to Health Care", I will be charged $4 for each medical service I request and a charge of $4 for each medication(s) dispensed to me, with the exceptions noted in the above-reference operations memorandum. There is no charge to the offender for mental health services and/or mental health medications.

Offender Signature Jerard Davis Date: 1.12.17

TO BE COMPLETED BY HEALTH SERVICES

Date Received 1/13/17 Initials

Comment: Refused

Shirley, RN
Qualified Health Care Professional

1/13/17
Date

NOTE: All "Keep on Person" (KOP's) medication refill requests must be submitted to the facility's health services unit or to the medical host facility, using the "Medication Refill Slip" (DOC 140130M). Medication Refill Slips" must be submitted within ten days of the date the medication expires or runs out. "Medication Refill Slips" are readily available and accessible at designated locations within the facility.

DOC 140117A
(R 10/15)

OKLAHOMA DEPARTMENT OF CORRECTIONS
WAIVER OF TREATMENT/EVALUATION
(Form must be completed in its entirety)

Facility OCF Date 1/13/17 Time 1021

I certify that I am refusing to consent to the following treatment/procedure/diagnostic test/medication/outside referral/laboratory at my own insistence and against the advice of the health care provider.

1. Refusal for: SCR - rash left side. - feet swelling, toes numb

2. Reason for the refusal: "nurse doesn't know what she's doing."

3. I have been informed by a qualified healthcare professional of the risks attendant to my refusal. These include: untreated, undiagnosed medical conditions. Resulting in infection, sepsis, organ failure, cardiac arrest, stroke, death

4. During the clinical interview which included counseling and education, the qualified healthcare professional has given me the opportunity to ask questions and has answered my questions.

5. I assume full responsibility for any results caused by my decision and I hereby release the institution, its employees, officers, and the provider from all legal responsibility and liability.

6. I certify that I am of sound mind and have read, or had read to me, and fully understand the above information concerning my refusal to accept treatment/evaluation and have had an opportunity to ask questions before I affix my signature.

7. I understand I may retract my decision and receive the treatment/procedure/diagnostic test/medication/outside referral/laboratory, although consequences due to the delay may result.

X _____ 1.13.17
Offender Signature Date

_____ 1/13/17
Qualified Healthcare Professional Date

_____ 1/13/17
Witness Date

If the offender refuses to sign such a statement, he/she cannot be forced to do so legally nor may release be withheld until the offender signs. If this occurs, the form should be filled out, witnessed by two facility personnel and the statement documented on the form, **"SIGNATURE REFUSED."**

Offender's Name	DOC NO.
Davis, Jerard	688165